



Government of the District of Columbia
Child and Family Services Agency



HUMAN CARE AGREEMENT CONTRACTOR QUALIFICATIONS RECORD

STATUTORY AND REGULATORY AUTHORITY

The Procurement Practices Human Care Agreement Amendment Act of 2000 (D.C. Law 13-155) authorizes the District of Columbia Chief Procurement Officer, or his or her designee, to award Human Care Agreements for the procurement of social, health, human, and education services directly to individuals in the District. The Human Care Agreement Contractor Qualifications Record (CQR) is an application package that will facilitate the process of pre-qualifying contractors for a Human Care Agreement with the District of Columbia in accordance with D.C. Law 13-155 and Chapter 19, 27 DCMR, the regulations.

GENERAL INSTRUCTIONS

1. Please read and complete each section of the Human Care Agreement Contractor Qualifications Record (CQR) form. All information must be completed in the spaces provided, or marked "N/A."
2. **Original signatures must be included. Copies or a stamped signature is not acceptable.**
3. Included in the package that will be provided to you will be a copy of the "Standard Contract Provisions for Use with District of Columbia Government Supply and Services Contracts", dated March 2007. Please read this document carefully before you complete the Contractor's Qualifications Record. The "Standard Contract Provisions For Use With District of Columbia Government Supply and Services Contracts," dated March 2007, will be incorporated by reference into each Human Care Agreement that is entered into between a Provider of human care services and the District of Columbia.
4. Also included in the package that will be provided to you will be forms required by the Department of Small and Local Business Development. You must complete those forms and return them with your package:
 - a. Compliance with Section 5 of Mayor's Order 85-85, "Equal Opportunity Obligations in Contracts" and
 - b. Compliance with Equal Opportunity for Local, Small and Disadvantaged Business Enterprises Amendment Act of 1998, as amended (D.C. Laws 12-268 and 13-169).
5. An electronic copy of Human Care Agreements and Contractor Qualifications Record Forms may be found on the CFSA website at: www.cfsa.dc.gov in the Contracts and Procurement link.
6. You may use the "Remarks Section", or attach a separate sheet, to provide additional information.
7. Please include and attach all information, documentation, and data as instructed and required.
8. In those instances where check boxes are provided, please check only the box or boxes which apply.

CHECKLIST

<input type="checkbox"/>	Did you include your Taxpayer Identification Number?	<input type="checkbox"/>	Did you attach a copy of your most recent Financial Statement?
<input type="checkbox"/>	Did you attach Disclosure Information?	<input type="checkbox"/>	Did you attach a copy of all licenses and certifications, including any specialty certifications?
<input type="checkbox"/>	Did you list all personnel critical to the performance of your Organization?	<input type="checkbox"/>	Did you attach a copy of the Certificate of Occupancy for each facility?
<input type="checkbox"/>	Did you attach a Certificate of Incorporation, if applicable?	<input type="checkbox"/>	Did you attach a Certificate of Good Standing, if applicable?
<input type="checkbox"/>	Did you attach a copy of your LSDBE certification, if applicable?	<input type="checkbox"/>	Did you attach or include your salary history, if applicable?



Government of the District of Columbia

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1. DATE OF FILING / /		2. FILING TYPE: <input type="checkbox"/> NEW <input type="checkbox"/> UPDATE <input type="checkbox"/> CORRECTION <input type="checkbox"/> REMOVAL		(FOR CFSA USE ONLY) DATE RECEIVED BY CFSA:	
SECTION I – GENERAL INFORMATION					
1. NAME OF INDIVIDUAL/ ORGANIZATION a. Name: b. Title: c. Physical Street Address: d. City, State & Zip Code:		2. TYPE OF ORGANIZATION : <i>(Please check the appropriate box.)</i> <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> JOINT VENTURE <input type="checkbox"/> CORPORATION <input type="checkbox"/> GENERAL PARTNERSHIP <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> LIMITED PARTNERSHIP			
		3. STATE OF INCORPORATION: <i>(Please check the appropriate box.)</i> <input type="checkbox"/> DISTRICT OF COLUMBIA <input type="checkbox"/> COMMONWEALTH OF VIRGINIA <input type="checkbox"/> STATE OF MARYLAND <input type="checkbox"/> STATE OF DELAWARE <input type="checkbox"/> OTHER: _____ Date Of: _____			
e. Office Phone: f. Office Facsimile No:		4. TYPE OF ORGANIZATION: <input type="checkbox"/> FOR PROFIT <input type="checkbox"/> NON-PROFIT			
g. E-Mail:					
5. SOCIAL SEC. / TAXPAYER ID NO:		6. DUNN & Bradstreet No:		7. ARE YOU OR THE ORGANIZATION CERTIFIED IN D.C. AS? <input type="checkbox"/> Small <input type="checkbox"/> Local <input type="checkbox"/> Disadvantaged <input type="checkbox"/> Resident-Owned <input type="checkbox"/> Enterprise Zone <input type="checkbox"/> Longtime Resident	
SECTION II – FINANCIAL RESPONSIBILITY INFORMATION <i>(Please Provide and Attach a Copy of Your Most Recent Financial Statement)</i>					
1. Name and Address of Accountant:		2. Name and Address of Financial Institution:			
3. Name and Title of Contact Person:		4. Name and Title of Contact Person:			
5. Telephone No.:		6. Fax No.:		7. Telephone No.:	
8. Fax No.:					
9. Date of Attached Financial Statement (must be within last 12 months):		10. Do You or the Organization Owe Any Outstanding District or Federal Taxes? District Taxes: <input type="checkbox"/> NO <input type="checkbox"/> YES Federal Taxes: <input type="checkbox"/> NO <input type="checkbox"/> YES			
11. MEDICAID – MEDICARE INFORMATION: a. Are You / Organization a Certified Medicaid Provider? <input type="checkbox"/> YES <input type="checkbox"/> NO Medicaid Number: _____ Date: _____ b. Are You / Organization a Certified Medicare Provider? <input type="checkbox"/> YES <input type="checkbox"/> NO Medicare Number: _____ Date: _____					

SECTION III – DISCLOSURE INFORMATION

(If “yes” to any questions below, please explain fully in REMARKS Section, or attach a separate statement)

1. Have you or the Organization ever been debarred, suspended or sanctioned from any state or federal program?
☐ YES ☐ NO
2. Is your license, or any in the organization, currently suspended or restricted in any way?
☐ YES ☐ NO
3. Have you or the principals of the Organization ever been, indicted, convicted of or pled guilty to a crime (excluding minor traffic citation), or been imprisoned for a crime in the past 10 years?
☐ YES ☐ NO
4. Are there any judgments, or pending civil lawsuits, or investigations against you or the Organization, or its principals?
☐ YES ☐ NO
5. Have you or the Organization ever had any outstanding criminal fines, restitution orders, or overpayments identified in the District or any state?
☐ YES ☐ NO
6. Are you, or is anyone in your organization, related by blood or marriage to any individual employed by the District government?
☐ YES ☐ NO (if you answered yes, please provide the information below)
- Name: _____ Relationship: _____

SECTION IV – ORGANIZATION HISTORY, BACKGROUND AND EXPERIENCE**1. List All Contracts With the District Government Within the Past Five (5) Years: (Continue in “Remarks” section or attached sheet)**

	Agency	Description of Service	Amount	Dates	Contract Number
A				to	
B				to	
C				to	
D				to	
E				to	

2. List All Contracts With Other Governments or Private Institutions Within the Past Five (5) Years: (Continue in “Remarks” section)

	Agency	Description of Service	Amount	Dates	Contract Number
A				to	
B				to	
C				to	
D				to	
E				to	

3. If You Are Applying As An INDIVIDUAL, Please List Your Employment Or Work History for past five (5) years:

(Continue in “Remarks” Section or attached sheet)

	Name of Employer	Address	Duties	Name of Supervisor	Dates of Employment	Telephone
A					to	
B					to	
C					to	
D					to	
E					to	

4. List At Least Five (5) References Familiar With Service Delivery: (Continue in "Remarks" section or attached sheet)						
	Name	Title/Position	Organization/Affiliation	Telephone	Fax	E-Mail
A						
B						
C						
D						
E						
ARE YOU A UNITED STATES CITIZEN?		ARE YOU A PERMANENT RESIDENT?		IF YOU ARE NOT A CITIZEN, KINDLY PROVIDE AND SUBMIT VERIFICATION OF YOUR LEGAL RIGHT TO WORK IN THE UNITED STATES.		
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO				
SECTION V – PERSONNEL CRITICAL TO PROVISION OF SERVICES EDUCATION, CREDENTIALS AND LICENSURE						
1. Please List Officers, Clinical Directors, Medical Directors, Social Workers, Residential House Managers, Mental Health Professionals, and Sub-Contractors essential to the provision of human care services in this CQR and attach relevant resumes, licenses, certifications, and/or credentials as applicable: (Continue in "Remarks" section or attached sheet)						
	Name	Title/Position	Degree and Educational Institution	License or Professional Certification	Active Dates of Licensure/ Certification	Contact Information
2. HAVE YOU OR ANY MEMBER OF THE ORGANIZATION EVER HAD ANY LICENSE, CERTIFICATION OR CREDENTIAL REVOKED OR SUSPENDED? <input type="checkbox"/> YES <input type="checkbox"/> NO						
<i>(If yes, please explain in "Remarks" Section, or attach a detailed explanation, including dates, type of license, certification, credential, and all circumstances surrounding the event(s).)</i>						

SECTION VI – SERVICE DATA AND INFORMATION

1. GENERAL SERVICE CATEGORIES: Please Check the General Service Categories for which this Application is Submitted :

<input type="checkbox"/> Adoption Services <input type="checkbox"/> After School Care <input type="checkbox"/> Developmentally Disabled Care <input type="checkbox"/> Diagnostic Assessment: 12 years and Younger (Chapter 62 licensure) <input type="checkbox"/> Diagnostic Assessment: 13 years and Older (Chapter 62 licensure) <input type="checkbox"/> Educational Services <input type="checkbox"/> Family Based Foster Care <input type="checkbox"/> Independent Living Main Facility Program (Chapter 63 licensure) <input type="checkbox"/> Independent Living Residential Units (Chapter 63 licensure)	<input type="checkbox"/> Health Services <input type="checkbox"/> Homemaker Services <input type="checkbox"/> Medically Fragile Care <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Mentoring Services <input type="checkbox"/> Respite Services <input type="checkbox"/> Residential Treatment Services <input type="checkbox"/> Substance Abuse Services	<input type="checkbox"/> Teen Bridge Program (Chapter 62 licensure) <input type="checkbox"/> Teen Parent Program (Chapter 63 licensure) <input type="checkbox"/> Therapeutic Group Home Care (Chapter 62 licensure) <input type="checkbox"/> Traditional Group Home Care (Chapter 62 licensure) <input type="checkbox"/> Tutoring Services
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2. LANGUAGE SKILLS: Please Check All that Apply in terms of Language Skills:

<input type="checkbox"/> English (ENG) <input type="checkbox"/> Spanish (SPN) <input type="checkbox"/> International/Universal Sign (SGN) <input type="checkbox"/> Italian (ITL)	<input type="checkbox"/> French (FRN) <input type="checkbox"/> Haitian Creole (CRE) <input type="checkbox"/> Vietnamese (VTN) <input type="checkbox"/> Korean (KOR)	<input type="checkbox"/> Chinese–Cantonese (CCA) <input type="checkbox"/> Chinese-Mandarin (CMA) <input type="checkbox"/> Ethiopian (Amharic) (AMH) <input type="checkbox"/> Others: _____
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SECTION V11 – REMARKS SECTION

Please use this section for additional response to any previous request for information. In addition, please feel free to use this section to provide additional information pertinent to determining qualifications for entering into a Human Care Service Agreement with the District of Columbia's Child and Family Services Agency.

SECTION VIII – CERTIFICATIONS AND INCORPORATIONS BY REFERENCE

1. DRUG-FREE WORKPLACE CERTIFICATION: *Please provide certification that you or the Organization will operate in a Drug-Free Manner.*

I/We, _____ of _____

Hereby give, affirm and provide certification that I/We have received and have read the requirements on having and maintaining a Drug-Free Workplace in the District of Columbia, agree to be bound by those requirements and the remedies stated in the requirements, and further certify that I/We realize that making a false, fictitious, or fraudulent certification may render the maker subject to prosecution under Title 18, United States Code, Section 1001.

Name (Please Print)	Title	Signature	Date
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(May be signed on behalf of individual or organization.)

2. STANDARD CONTRACT PROVISIONS FOR USE WITH DISTRICT OF COLUMBIA SUPPLY AND SERVICES CONTRACTS: *Please provide Certification that You or the Organization Agree to be bound by the Standard Contract Provisions of the District of Columbia.*

I/We, _____ of _____

Hereby give, affirm and provide certification that I/we have received and have read the Standard Contract Provisions For Use With District of Columbia Government and Supply Contracts ("Standard Contract Provisions"), dated November 2004, and agree to be bound by all of the provisions, including The requirements of the Occupational Safety and Health Act of 1970 (as amended), the Service Contract Act of 1965 (41 U.S.C. 351-358), the Buy America Act (41 U.S.C.), and the Non-Discrimination provisions. Further, I/We agree and understand that the Standard Contract Provisions shall be Incorporated by reference into any contract or agreement that shall be signed between Me, or My Organization, and the District of Columbia.

Name (Please Print)	Title	Signature	Date
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3. INFORMATION CONSENT: *Please Provide Certification that you or the organization Provide Consent To The District To Obtain Additional Information As Needed.*

I/We, _____ of _____

Hereby give, provide and express my consent for representatives of the Office of Contracting and Procurement, Government of the District of Columbia, to obtain any information from any professional organization, business entity, individual, government agency, or academic institution concerning the Professional license status or certification referenced in this document. This material shall be held, maintained and updated by the Office of Contracting and Procurement. I further understand that the Office of Contracting and Procurement will use this information solely for internal purposes pertaining to the evaluation of the qualifications of individuals and organizations to provide human care services, as appropriate, in the District of Columbia.

Name (Please Print)	Title	Signature	Date
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**Government of the District of Columbia
Child and Family Services Agency**

CONGREGATE CARE HUMAN CARE AGREEMENT

Specialized Experience for Human Care Agreement Contractor's Qualifications Record (COR) response:

- Submit evidence that the prospective provider meets the District of Columbia's licensing financial standards with documentation of at least three (3) months operating costs.
- Submit evidence that the prospective provider possesses current license in the congregate service category for which they are applying.
- Submit evidence that the prospective provider has at least five (5) years of demonstrable experience in providing services for abused and neglected children.
- Submit evidence that the prospective provider has at least three (3) recent service evaluation reports which demonstrate favorable and positive performance for children in their facilities.
- Submit evidence that the prospective provider's organizational structure will have a Quality Assurance System which includes a QA coordinator to manage programmatic outcomes, Placement Provider Web (PPW) data and other performance indicators.